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E 000	Initial Comments On January 22, 2014 an Inspection of Care survey was conducted by representatives of the Office of Health Care Quality (OHCQ) to determine whether the immediate health and safety needs of the residents are being met and determining compliance with COMAR regulations 10.07.14, Assisted Living Program Regulations. Survey activities included a review of selected administrative, staff and residents' files, interview with staff and residents, observations, and a tour of the facility. The facility census at the time of the survey was 28 residents.	E 000		
E2600	.19 B6,7 .19 Other Staff--Qualifications (6) Receive initial and annual training in: (a) Fire and life safety, including the use of fire extinguishers; (b) Infection control, including standard precautions, contact precautions, and hand hygiene; (c) Basic food safety; (d) Emergency disaster plans; and (e) Basic first aid by a certified first aid instructor; (7) Have training or experience in: (a) The health and psychosocial needs of the population being served as appropriate to their job responsibilities; (b) The resident assessment process; (c) The use of service plans; and (d) Resident's rights; and This REQUIREMENT is not met as evidenced by: Based on administrative and staff record review	E2600		

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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E2600	Continued From page 1 and interview with the Delegating Nurse (DN) on 1/22/14, the licensee failed to have evidence of Emergency Disaster Plan training as required. Findings include: Administrative and staff record review and interview with the DN on 1/22/14 failed to provide evidence of Emergency Disaster Plan training for six of the six staff records reviewed.	E2600		
E2730	.19 G4 .19 Other Staff--Qualifications (4) Ongoing training in cognitive impairment and mental illness shall be provided annually consisting of, at a minimum: (a) 2 hours for employees whose job duties involve the provision of personal care services as described in Regulation .28D of this chapter; and (b) 1 hour for employees whose job duties do not involve the provision of personal care services as described in Regulation .28D of this chapter. This REQUIREMENT is not met as evidenced by: Based on administrative and staff record review and interview with the DN on 1/22/14, the licensee failed to have evidence of annual training in cognitive impairment and mental illness for Staff #1 and Staff #6. Findings include: Administrative and staff record review and interview with the DN on 1/22/14 revealed no evidence of current annual training in cognitive impairment and mental illness for Staff #1 and Staff #6.	E2730		
E2780	.20 C .20 Delegating Nurse	E2780		

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E2780	Continued From page 2 C. Duties. The delegating nurse shall: (1) Be on-site to observe each resident at least every 45 days; (2) Be available on call as required under this chapter or have a qualified alternate delegating nurse available on call; and (3) Have the overall responsibility for: (a) Managing the clinical oversight of resident care in the assisted living program; (b) Issuing nursing or clinical orders, based upon the needs of residents; (c) Reviewing the assisted living manager's assessment of residents; (d) Appropriate delegation of nursing tasks; and (e) Notifying the OHCQ: (i) If the delegating nurse's contract or employment with the assisted living program is terminated; and (ii) Of the reason why the contract or employment was terminated. This REQUIREMENT is not met as evidenced by: Based on administrative and resident record review and interview with the DN on 1/22/14, the DN failed to document management of clinical oversight as required. Findings include: Administrative and resident record review and interview with the DN revealed that the DN documentation does not offer appropriate recommendations and direction to staff. Examples include: Review of the DN documentation for Resident #1 revealed that this resident has behavior issues including being irritable with staff. Further review revealed that the DN's recommendations and	E2780		

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E2780	Continued From page 3 direction to staff around these behaviors include, "continue to monitor". Review of the DN documentation for Resident #2 revealed that this resident refuses care quite regularly. Further review revealed that the DN's recommendations and direction to staff around these refusals include, "redirect as able", "monitor", and adding an anti-anxiety medication with minimal results.	E2780		
E3330	.26 B1,2 .26 Service Plan B. Assessment of Condition. (1) The resident's service plan shall be based on assessments of the resident's health, function, and psychosocial status using the Resident Assessment Tool. (2) A full assessment of the resident shall be completed: (a) Within 48 hours but not later than required by nursing practice and the patient's condition after: (i) A significant change of condition; and (ii) Each nonroutine hospitalization; and (b) At least annually. This REQUIREMENT is not met as evidenced by: Based on resident record review and interview with the DN on 1/22/14, the licensee failed to base each resident's service plan on their Resident Assessment Tool, and failed to complete a Resident Assessment Tool after a hospitalization. Findings include: Review of six of the six resident records reviewed revealed that each resident's service plan was not based on the resident assessment tool as	E3330		

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E3330	Continued From page 4 required. Cross TAG E3360. Review of Resident #5's record revealed that this resident was sent to the Emergency Department of a local hospital on 8/9/13 due to a headache and complaint of feeling "fuzzy". Further review and interview with the DN revealed that this resident's Resident Assessment Tool was not completed after this event. This resident's most current Resident Assessment Tool is dated 7/23/13.	E3330		
E3360	.26 C1 .26 Service Plan C. The assisted living manager, or designee, shall ensure that: (1) A written service plan or other documentation sufficiently recorded in the resident's record is developed by staff, which at a minimum addresses: (a) The services to be provided to the resident, which are based on the assessment of the resident; (b) When and how often the services are to be provided; and (c) How and by whom the services are to be provided; This REQUIREMENT is not met as evidenced by: Based on review of six of the six resident records reviewed, the licensee failed to address the services to be provided to the residents which are based on the assessment of the resident including when and how often services are to be provided and how and by whom the services are to be provided. Findings include:	E3360		

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E3360	Continued From page 5 Examples include: Review of Resident #1's record revealed that this resident has eight documented diagnoses, however only two of these diagnoses are adequately addressed on the service plan. Further review revealed that this resident has documented behavior issues that are not addressed in the service plan. Review of Resident #2's record revealed that this resident has six documented diagnoses, however none of these diagnoses are adequately addressed in the service plan. Further review revealed that this resident refuses care quite frequently due to agitation, and the service plan states "re-direction", and "followed by psych" as services for this frequent issue. Review of Resident #3's record revealed that this resident has seven documented diagnoses, however none of these diagnoses are adequately addressed in the service plan. Further review revealed that this resident frequently calls out, "help me". The service plan states "redirect", "followed by med options" as the service for this yelling out. The service plan does not suggest services to be provided to this resident as she continues to call out "help me". Review of Resident #4's record revealed seven documented diagnoses, including diabetes, seizure disorder, high blood pressure and depression. Further review of the service plan revealed statements as, "A&O x 3 with mild memory impairment, fair judgement." Continued review revealed no appropriate services listed for this resident's diagnoses. It is recommended that the licensee consider using the Service Plan template on the OHCQ	E3360		

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E3360	Continued From page 6 website to comply with this deficiency. It is also recommended that the licensee consider using the Service Plan template on the OHCQ website for all future Service Plans of all residents of the facility. Cross TAG E3330	E3360		
E3660	.29 L1,2 .29 Medication Management and Administration L. Safe Storage of Medication. The assisted living manager, or designee, shall ensure that: (1) Medications are stored in the original dispensed container; (2) Medications are stored in a secure location, at the proper temperature; and This REQUIREMENT is not met as evidenced by: Based on observation during a tour of the facility and interview with the DN on 1/22/14, the licensee failed to secure medications as required. Findings include: Observation during a tour of the facility and interview with the DN on 1/22/14 revealed Sodium Sulfacetamide powder (prescription medication used to treat skin conditions) and another prescription medication located on the dresser in resident room #4410. Continued observation during a tour of the facility revealed Saline Nasal Spray, Vicks VapoRub, Neosporin and Visine in the bathroom of resident room #3312.	E3660		
E3680	.29 M .29 Medication Management and Administration	E3680		

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E3680	Continued From page 7 M. Medications and treatments shall be administered consistent with current signed medical orders and using professional standards of practice. This REQUIREMENT is not met as evidenced by: Based on administrative and resident record review, observation of the medications and interview with staff, the licensee failed to ensure that medications are administered consistent with current signed medical orders and using professional standards of practice. Findings include: Review of Resident #5's record revealed an order for Tramadol HCL tab, 50 milligrams. Review of the January, 2014 Medication Administration Record (MAR) revealed that this order had been discontinued. Observation of Resident #5's medications revealed a bottle of Tramadol. Review of Resident #2's record revealed a PRN order for nebulized Ipratropium (used to treat COPD) and a PRN order for Patarol opth sol 0.1% eye drops. Observation of this resident's medications revealed neither medication. Interview with the LPN giving medications and the DN revealed that neither medication was available for this resident at the time of the survey.	E3680		
E3690	.29 N1 .29 Medication Management and Administration N. Required Documentation. (1) A staff member shall record the documentation required under §L of this	E3690		

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E3690	Continued From page 8 regulation for all residents for whom medications are administered, or who receive assistance in taking their medications, as defined by Regulation .02B(3)(b) of this chapter, at the time that the resident takes or receives medications. This REQUIREMENT is not met as evidenced by: Based on administrative and resident record review and interview with staff on 1/22/14, the licensee failed to ensure that medications are signed off at the time of medication administration as required. Findings include: - Review of Resident #3's January, 2014 Medication Administration Record (MAR) revealed a transcription, "Nector thickened water 100 ml every 3 hours." Further review revealed that on 1/21/14 the 6:00 pm and the 9:00 pm "doses" were not signed off as being administered. Staff indicated that this order surely was administered, not signed off. Further review revealed an order for "Amitriptyline (medication to treat depression) 10 milligrams, 2 tabs by mouth". Further review revealed that the 5:00 pm dose on 1/21/14 was not signed off as being administered to Resident #3. Staff indicated that this order surely was administered, not signed off. Continued review revealed an order for "LubriFresh tears" (used to treat dry eyes) and an order for Risperidone (antipsychotic) 0.5 milligrams. Further review revealed that the 5:00 pm doses on 1/21/14 were not off as being administered to Resident #3. Staff indicated that these orders surely were administered, not signed off.	E3690		

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E3690	Continued From page 9 - Review of Resident #5's January, 2014 MAR revealed that this resident's Doxycycline (antibiotic) 100 milligrams, Tricor (lipid regulating agent) 145 milligrams, and Protonix (treats reflux) 40 milligrams were not signed off as being administered on 1/21/14. Staff indicated that this order surely was administered, not signed off.	E3690		
E5240	.48 F4(i) .48 Common Use Areas (i) Shall provide refrigeration operated at or below 45°F and equipped with an indicating thermometer graduated at 2°F intervals; and This REQUIREMENT is not met as evidenced by: Based on observation during a tour of the facility and interview with the ALM on 1/22/14, the licensee failed to provide a thermometer in the refrigerator in resident room #3301. Findings include: Observation during a tour of the facility and interview with the ALM on 1/22/14 revealed no thermometer in the refrigerator in resident room #3301.	E5240		